Record-keeping essentials

What a clinical record holds, how to write and amend it, appointment and financial records, how long to keep them, how to keep them safe, and a client's rights of access and correction.

Study aid, not legal advice. Last verified against the official sources linked below on 11 November 2026.

1 What the clinical record holds (Standard 5.1)

- **Client profile**: name, address, phone, date of birth, any legally authorized representative, who referred and why.
- **Assessment**: methods, results, conclusions, problem formulation.
- **Plan for therapy**, with each consent given.
- **Progress notes**: the client's statements, your observations, impressions and plans.
- **Consultations and referrals**, each with its date and details.
- **Reports** sent or received; a copy of each mandatory report, or a written summary of a verbal one.
- **Incident reports** for any major, unexpected negative outcome, with action and follow-up.
- **Closing**: reasons, a summary of outcomes, referrals or follow-up.
- **Not part of it**: rough notes (complete the record, then destroy them the same day) and notes on your own process that do not identify the client.

2 How to write it (5.1)

- **Accurate, complete, legible**, in plain language, updated in a timely way (5.1.1).
- Key information in **English or French**; progress notes may be in the language of therapy.
- **Each entry** shows the client's name or unique identifier, the date, and who wrote it.
- **Amend openly**: what changed, when, by whom and why, the original still legible.
- **Misconduct**: failing to keep records to the profession's standards, signing a false or misleading document, or falsifying a record (O. Reg. 317/12, s. 1, paras. 25 to 27).

3 Appointment and financial records (5.4, 5.5)

- **Appointments**: an appointment and attendance record for each client, with the date, time and length of each encounter and any cancelled or missed appointment (5.4.1); central or in each file.
- **Financial record** for every client charged a fee (5.5.1): who provided the service and their title; the client's full name, address and any unique identifier.
- **The service**, its cost, and the date and method of payment; fees for services by supervised personnel.
- **Reductions** or waivers and why; a third-party payer's full name and address; any balance owing; any collection agency retained.
- **Separate** from the clinical record if you wish, but secure and easy to retrieve (5.5 commentary).

4 How long to keep them

- Example: last seen at age 7, kept until the 28th birthday.

Record	Keep at least
Clinical (5.1), when you are the custodian	10 years from the last interaction or from the client's 18th birthday, whichever is later
Appointments (5.4)	The same
Financial (5.5)	The same

5 Keeping them safe (5.6)

- **Reasonable steps** against theft, loss, and unauthorized use, disclosure, modification or disposal (5.6.1).
- **Policies**: write them if you are the custodian (you, in solo practice); otherwise follow your group practice's or employer's.
- **Physical**: locked spaces, screens out of view, micro-cut shredding.
- **Electronic**: firewalls, encryption, passwords, tested backups, an audit trail of entries, views and exports, a fallback if the system fails.
- **Administrative**: need-to-know access, confidentiality agreements, privacy training, a disposal log.
- **In transit**: tracked mail or courier, or encrypted transmission.
- **Your system** must retrieve, transfer, amend (keeping the original) and securely destroy records, organized so they are easy to find.

6 Access and correction (PHIPA ss. 52 to 55)

- **A right of access**, except where it could, for example, risk serious harm to treatment or recovery, or serious bodily harm (s. 52 (1) (e)); give what can be severed (s. 52 (2)).
- **In writing**, with enough detail to find the record (s. 53).
- Answer **within 30 days at most**; one extension of up to 30 days, with written notice (s. 54 (2) to (4)). No answer is a **deemed refusal** (s. 54 (7)).
- A fee no higher than reasonable **cost recovery**, which you may waive (s. 54 (10) to (12)).
- **Correction**: correct what the client shows is inaccurate or incomplete, within the same 30 days (s. 55); a good faith professional opinion need not change. A refused client may attach a statement of disagreement.

Write it plainly, amend it openly, keep it ten years after the later date, and let clients see it.

Official sources: CRPO Standard 5.1: Clinical Records and 5.4: Appointment Records and 5.5: Financial Records and 5.6: Record Storage, Security & Retrieval and PHIPA, 2004 and O. Reg. 317/12 (paras. 25 to 27). Condensed from Record-keeping and Documentation and The Legal Framework. Independent study aid, not legal advice, not affiliated with CRPO or COMPASS.